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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 20 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 16493

Registrar's No. 4492

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo-5 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 9/6
(If outside city or town limits, write "RURAL")

(d) Street No. 3540 Arkansas
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Adam Kile (ADAM KEIL)

3. (b) If veteran, name war Unk.

3. (c) Social Security No. Unk.

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unk. (Month) About 1867 (Day) (Year)

8. AGE: Years About 76 | Months | Days | If less than one day hr. min.

9. Birthplace Missouri (City, town, or county) 0 (State or foreign country)

10. Usual occupation Unk.

11. Industry or business

FATHER
12. Name Unk.
13. Birthplace Unk. (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unk.
15. Birthplace Unk. (City, town, or county) 9 (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-16-44 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis Oldest Peter Mark

18. (a) Signature of funeral director Thomas W. Kirkton
(b) Address 2906 Gravois 3500 Rutgers St

19. (a) MAY 15 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9th
year 1944 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from April 4th, 1944, to May 9th, 1944
that I last saw him alive on May 9th, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: arteriosclerotic heart disease	22
Due to: Incarcerated inguinal hernia Rt. and left	7 days
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations inguinal hernia Bilateral
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
(e) While at work? (e) Means of injury

23. Signature D. J. Verda, (M. D. or other)
Address 1515 Lafayette Date signed 5/9/44

Reclaimed from Abstract Board - 5-15-44

(Licensed Embalmer's Signature)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.